STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445300	A. BUILDING _____ B. WING _____	06/29/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIDGEVIEW TERRACE OF LIFE CARE	PO BOX 26 COFFEY LANE RUTLEDGE, TN 37861

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on medical record review, facility investigation, and interview, the facility failed to ensure that residents were free from medication errors for one resident (#19) of twenty-eight residents reviewed. The findings included: Resident #19 was admitted to the facility on March 4, 1998, with diagnoses including Mental Retardation, Hypertension, and Hypothyroidism. Medical record review revealed a nurse's note dated December 24, 2010, at 7:15 a.m., by LPN #1 revealed "...Res (resident) received wrong meds (medications), MD notified, new orders rec (received) et (and) noted - to monitor BPs (blood pressures) et APs (apical pulse rate/heart rate) hourly et call MD back with drop in BP/AP..." Continued medical record review revealed an order was also received to hold administration of resident #19's prescribed blood pressure medications (Nitroglycerin 0.2mg (milligram)/hr (hour) patch and Demadex 20mg tablet) for the morning of December 24, 2010. Review of facility investigation dated December 27, 2010, further revealed that a medication error had occurred on December 24, 2010, at 6:15 a.m., during the morning medication pass, when	F 333	This Plan of Correction is submitted as required under Federal and State regulations and statues applicable to long-term care providers. This Plan of Correction does not constitute an admission of liability on the part of the facility, and such liability is hereby specifically denied. The submission of this Plan does not constitute agreement by the facility that the surveyors' findings or conclusions are accurate, that the findings constitute a deficiency, or that the scope and severity regarding any of the deficiencies are correctly applied. CORRECTIVE ACTION: Resident #19's physician was immediately notified of the error on 12/24/10. Orders were received and carried out to monitor the resident's blood pressure and apical pulse and notify the physician of any drop. RESIDENTS WITH POTENTIAL TO BE AFFECTED: Medication pass skills checks will be performed for all licensed nurses by nursing administration to ensure licensed nurses are following facility procedures for medication pass.	

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Karen Bumgarner — Executive Director — 7/8/11

y deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that ner safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days lowing the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 ys following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued ogram participation.

JUL 11 2011

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	445300	A. BUILDING _____ B. WING _____	06/29/2011

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RIDGEVIEW TERRACE OF LIFE CARE	PO BOX 26 COFFEY LANE RUTLEDGE, TN 37861

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F 333	Continued From page 1 LPN #1 administered three pills prescribed for another resident to resident #19. Continued medical record review revealed two of the three medications administered were blood pressure medications (Lisinorpil 40mg and Lasix 20mg). Interview with the DON (Director of Nursing) on June 29, 2011 at 9:10 a.m., at the 100/200 hall nursing station confirmed resident #19 received the wrong medications as described above.	F 333	SYSTEMIC CHANGES: Licensed nurses were inserviced by the Director of Nursing on 7/5/11 on medication administration. MONITORING: Medication pass audits will be conducted for licensed nurses on each shift and each hall monthly by nursing administration to ensure accurate medication administration. Results of audits will be presented by the Director of Nursing and reviewed in monthly Performance Improvement (PI) committee meeting for 3 months.	7/31/11
F 505 SS=D	483.75(j)(2)(ii) PROMPTLY NOTIFY PHYSICIAN OF LAB RESULTS The facility must promptly notify the attending physician of the findings. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview the facility failed to promptly notify the physician of laboratory results for one resident (#9) of twenty-eight residents reviewed. The findings included: Resident #9 was admitted to the facility December 30, 2009, with diagnoses including Hemiplegia, Parkinson's Disease, Stroke, Dysphagia, and Pressure Sore of the Right Heel. Medical record review of a nurse's note dated October 16, 2010, at 8 a.m., revealed "...FNP (Family Nurse Practitioner) at facility, assessed Rt (right) heel at nurse's request..." Medical record review of a physician's telephone	F 505		

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F 505	Continued From page 2 order dated October 16, 2010, revealed "...wound c/s (culture and sensitivity) of R (right) heel; fax results to office..." Medical record review of the laboratory results dated October 25, 2010, revealed the culture sample was collected on October 17, 2010. Medical record review of a nurse's note dated October 25, 2010, at 9:05 a.m., revealed "...faxed preliminary wound culture from R heel, results to...(physician's name) office at 7 a.m. this morning." Medical record review of a nurse's note dated October 28, 2010, at 3 p.m., revealed "...C&S refaxed to MD (medical doctor) per MD request..." Medical record review of a physician's telephone order dated October 28, 2010, revealed "...Bactrim DS 1 PT (per tube) BID (twice daily) x 7 days..." Interview with the DON (Director of Nursing) June 29, 2011, at 10:45 a.m., in the conference room, confirmed the physician was not notified promptly of the wound culture results for this resident resulting in a delay of care.	F 505	CORRECTIVE ACTION: Resident #9's physician was notified of his lab results via fax on 10/25/10 and 10/28/10. New orders were received from the physician on 10/28/10. RESIDENTS WITH POTENTIAL TO BE AFFECTED: Lab results received by the facility in the past 30 days will be reviewed by nursing administration to ensure notification to physician. SYSTEMIC CHANGES: Licensed nurses were inserviced by the Director of Nursing on 7/5/11 on prompt physician notification of lab results. MONITORING: Audits of laboratory results will be conducted by the Director of Nursing/Assistant Director of Nursing weekly to ensure physician notification of results. Results of audits will be presented by the Director of Nursing and reviewed in monthly Performance Improvement (PI) committee meeting for 3 months.	7/31/11

JUL 11 2011